DOCUMENT RESUME

ED 418 352 CG 028 371

AUTHOR Boller, Janet L.; Lee, Sandra S.
TITLE Nonsexual Touch, Self-Disclosure, and Friendship in the Therapeutic Setting: A Discussion of Boundary Issues.
PUB DATE 1997-00-00
NOTE 18p.
PUB TYPE Information Analyses (070)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Adults; Counseling Techniques; *Counselor Client Relationship; Ethics; Friendship; Interpersonal Relationship; *Psychotherapy; Termination of Treatment
IDENTIFIERS *Boundaries

ABSTRACT

Conflict over appropriate treatment boundaries has been an issue since the time of Freud. To better understand these boundaries, some traditional, humanistic and feminist models which range from conservative, strict boundaries to more liberal or relaxed boundaries are considered here. The ethical considerations and implications of nonsexual touch, post-treatment friendship, and therapist self-disclosure are addressed under the common theme of boundary construction. The goal of this work is to provide a framework for designing and understanding boundary violations. Current literature is reviewed briefly to highlight opposing views as well as to facilitate a working knowledge of the nature of the ethical dilemmas raised in boundary construction. Finally, an alternative theoretical approach for decision-making is proposed. (Contains 24 references.) (EMK)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

Running head: BOUNDARY ISSUES IN THE THERAPEUTIC SETTING

ED 418 352

Nonsexual Touch, Self-Disclosure, and Friendship in the Therapeutic Setting: A Discussion of Boundary Issues

Janet L. Boller

Sandra S. Lee, Ph.D.

Seton Hall University

CG028371

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

S. LEE

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

BEST COPY AVAILABLE

Abstract

In this paper, the ethical considerations and implications of nonsexual touch, post-treatment friendship, and therapist self-disclosure will be explored. Though each of these can be considered a separate issue, they will be addressed collectively under the common theme of boundary construction. The goal of this work will be to provide a framework for defining and understanding boundary violations. Current literature on this topic will be briefly reviewed. This review will highlight opposing viewpoints as well as facilitate a working knowledge of the nature of the ethical dilemmas raised in boundary construction. Finally, an alternative theoretical approach for decision-making will be proposed.

Introduction:

Conflict over appropriate treatment boundaries has been an issue since the late 20th Century . Freud recommended and emphasized the importance of neutrality, yet analyzed his own daughter. Other major figures in the field of psychotherapy provided equally ambiguous messages. For example, Ferenczi conducted dual analysis with one of his patients while Klein took a vacation with one of hers (Simon, 1992; Gutheil & Gabbard, 1993.) Issues of nonsexual touch, post-treatment friendship, and therapist self-disclosure are each related to an overall concept of strict versus loose boundaries in a therapeutic setting. Different schools of thought take opposing positions regarding the acceptability of these behaviors. Though there is disagreement within the field as to how to make ethical boundary decisions, there is considerable agreement that the current guidelines tend to be both vague and subjective (Simon, 1993; Sonne, 1994; Smith & Fitzpatrick, 1995).

A review of the current literature will highlight altering viewpoints as well as facilitate an understanding of some of the ethical dilemmas that are raised when professionals are faced with questions of boundary issues. The different points of view will consist of traditional, humanistic, and feminist models which range from conservative, strict boundaries to more liberal or relaxed boundaries. Some of the issues that are raised in this discussion are related to maintaining the integrity of the therapeutic work, transference issues, gender issues, and, ultimately, the potential harm to the patient. In addition, an alternative theoretical approach to address the questions raised herein will be proposed.

Literature Review:

An initial review of current literature reveals both equivocal and opposing opinions surrounding the issue of boundary construction. A wide range of acceptable behavior is

described. This review will be structured to highlight opposing sides of the issue. First, arguments for maintaining strict boundaries will be discussed followed by arguments for allowing relaxed boundaries.

Strict Boundaries:

In their book, Keeping up the Good Work, Haas and Malouf (1995) clearly illustrate the amount of room for interpretation with regard to this dilemma. They suggest that dual relationships are not inherently unethical and that the professional must be both aware of and responsible for potential harm. The authors argue that an "asymmetry of power" exists between patient and therapist. In other words, therapists typically disclose little about themselves and yet uncover a wealth of information about patients who are often at their most vulnerable. By definition, according to this position, a mutual relationship or friendship would be impossible because no genuine mutuality exists -- it is inherently a relationship of unequal power. The patient will always be unequal or subordinate in such an arrangement.

Epstein (1994) makes a strong argument for the necessity of maintaining clear and strict boundaries, though even his definition of a boundary violation is subjective and ambiguous. He attempts to be more explicit by presenting an inventory of boundary guidelines necessary to help maintain the integrity of treatment. He suggests guarding against personal relationships and physical contact while remaining anonymous and neutral.

Epstein (1994) also presents a useful discussion of ego boundaries and a regression to primary process thinking. He argues that, as patients naturally regress during the therapeutic process, the formulation of strong boundaries between the therapist and patient is even more crucial. A key element in this concept is that even healthy adults retain primary process thinking within their unconscious capacities; patients, therefore, may be even more vulnerable to such

regression. Because primary process thinking precedes the ability to distinguish between self and other, a therapist who permits loose boundaries, according to this argument, may also promote a pathological regression in which self and other (patient and therapist) are indistinguishable. As infants, we rely on our primary caregiver to function as our ego boundary. In therapy, the therapist should do the same.

Other arguments favoring strict boundary construction focus on different topics. Many caution against the dangers of progressive boundary crossing (Epstein, 1994; Gutheil & Gabbard, 1993; Simon, 1993; Holub & Lee, 1990). Also, the nature of the transference process is considered. It is widely held (Epstein, 1994; Kertay & Reviere, 1993; Smith & Fitzpatrick, 1995) that transference is an essential element in psychotherapy which necessitates a certain degree of neutrality. As such, self-disclosure, mutuality, and touch could destroy its potential. In addition, it is suggested that indistinct boundaries may cause particular concern for patients who come from situations where psychological or physical boundaries have been inappropriate in the past (Miller & Lee, 1990). Finally, if a friendship ensues post termination, the patient will be precluded from ever returning to therapy with the same therapist (Miller & Lee, 1990; Haas & Malouf, 1995).

Relaxed Boundaries:

It is interesting to point out that several sources which favor relaxd boundary construction were written by women with a feminist orientation to therapy (Wooley, 1994; Lerman & Porter, 1990; Lerman & Rigby, 1990; Greenspan, 1986; Heyward, 1993). Lerman and Rigby (1990) argue that feminist therapists are particularly sensitive to power imbalances, especially those within the field of psychology. Moreover, Lerman and Porter (1990) write that current ethical guidelines do not consider the danger of both ends of extreme behavior in boundary dilemmas.

They criticize the APA Code for failing to address the potential harm caused by the emotionally distant therapist and for failing to offer guidelines to prevent harm from occurring. Both Greenspan and Wooley agree, arguing that the traditional model of therapy is based on a male perspective which encourages distance and control.

One particularly poignant book was written by a patient who felt betrayed by her therapist's unwillingness to be her friend following the termination of therapy. In her book, When Boundaries Betray Us, Carter Heyward (1993) describes her close connection and therapeutic relationship with her therapist. The relaxed boundary which included hugging and self-disclosure became a violation in Heyward's eyes when the therapist refused to not only consider a post-treatment friendship, but also to seek consultation to examine the boundary issues involved. Though written from a non-clinical point of view, this text can serve as a useful illustration for this discussion and I will return to it later.

Other therapeutic orientations also favor relaxed boundaries. In a humanistic point of view, for example, Mintz (1969) outlines specific examples of when touch is acceptable. For example, touch offered as symbolic mothering, acceptance, or contact with the external world would be ethical. Kertay and Reviere (1993) also define a decision-making model for considering the use of touch. Their approach consists of three levels which address the following three concerns: exploitation, the stage of the relationship, and theoretical considerations. Finally, there is the belief that touch can serve as an alternative form of communication with patients at those times when words fail (O'Hearne, 1972). Though these approaches offer a positive look at the issue of touch, they still fail to address a wider range of boundary dilemmas.

Clearly, there are no definitive answers to the question of what constitutes a boundary violation. However, what may be most notable in the contrast between arguments for and

against strict boundary construction is that the two positions are often not as extremely opposed as one might first assume. In fact, there is a considerable degree of middle ground. This is further demonstrated in much of the literature which offers a distinction between harmful and non-harmful boundary crossings.

Violations Versus Crossings:

Gutheil and Gabbard (1993) make a distinction between boundary crossings and violations. Crossings represent any departure from common practice without the imposition of judgment. Violations, however, would indicate a harmful crossing. Referring to Gutheil and Gabbard's work, Smith and Fitzpatrick (1995) also place boundary transgressions on a continuum. They write that minor crossings, when properly examined, can provide focus for the therapeutic work. Self-disclosure, for example, may be a powerful tool for providing insight which may allow the patient to overcome a therapeutic impasse. In her book, The Therapist as a Person, Barbara Gerson (1996) offers poignant case examples of this issue, which illustrate the complexity of weighing the potential benefit or harm when making various types of boundary decisions. Finally, Simon (1992) writes that any boundary exceptions must serve to benefit the patient. Brief violations, he argues, may provide insight into conflictual issues for both parties.

The extent of ambiguity has prompted some authors to propose alternate guidelines and recommendations for change. These suggestions, in addition to an original framework, will be presented in the following sections.

Alternate Guidelines and Recommendations:

Epstein and Simon (1990) developed an Exploitation Index, a self-assessment tool designed to indicate boundary violations within the therapeutic setting. The following subcategories of exploitation are utilized: general boundary violations, eroticism, exhibitionism,

dependency, power seeking, greed, and enabling. Within each subcategory, the therapist answers three to seven questions by indicating that s/he "never", "rarely/ yearly", "sometimes/ quarterly", or "often/ monthly" engages in the described activity or experiences the described feeling. Though validation of the instrument had not been tested, the authors hope that the instrument can be used to initiate discussion and increase awareness.

Several authors (Lerman & Porter, 1990; Smith & Fitzpatrick, 1995; Sonne, 1994) stress the need for increased awareness and education standards with regard to boundary issues. In addition to education, Smith and Fitzpatrick recommend the following as a technique for preventing boundary violations: seek consultation, supervision and/or personal therapy. Sonne concurs, suggesting that professional guidelines should include consultation as an integral part of codes for addressing boundary issues.

Finally, Smith and Fitzpatrick (1995) offer the following recommendations which can help decrease the harmful effects of boundary crossings: Boundary crossings must be justified with sound clinical reasoning, crossings should be documented, and crossings should be viewed as opportunities to further the therapeutic process.

Proposal for Alternative Framework:

An alternative model for determining one's own theoretical orientation toward boundary issues is proposed. As demonstrated above, therapists have a considerable degree of room to make their own decisions regarding method of treatment. Alternative models and framework for understanding boundary issues, such as those described above, are useful for a couple of reasons. First, they pose questions in new ways and, thus, raise the potential for further awareness. Another important reason to encourage alternate approaches is that all therapists are different, and guidelines which assist one person with the boundary decision process may not help others.

The following framework stems from the most basic tenet, which is to do no harm to the patient. As the concept of harm is equally ambiguous, a theoretical approach for determining harm to a patient is offered.

Motivation should be a primary consideration for any therapist when faced with a boundary dilemma. This issue was implicit in the various boundary guidelines reviewed earlier. In this regard, determining the patients needs or desires may be useful. For the purpose of explaining the need versus desire model, consider the following scenario.

Scenario 1) A patient walks into the therapist's office and asks for a glass of milk.

Scenario 2) A patient has rushed to get to therapy on time because the bus was late and has just run down the block and up a flight of stairs. Out of breath, the patient asks for a glass of water.

In either situation, should the therapist meet the patient's request? This is, obviously, an oversimplification of the question of meeting needs versus desires in the therapeutic setting. Though simplified, the example serves as an illustration of what could be a different type of therapeutic dilemma. Ultimately, according to the proposed model, Scenario 1 represents a desire, and should, therefore, not be gratified. However, Scenario 2 represents a need and may be granted. With regard to the overarching theme of this paper, it is suggested that meeting a desire would constitute a boundary violation whereas meeting a need would not. The reasons for these decisions will be further discussed.

In his book, Hope and Dread in Psychoanalysis, Stephen Mitchell (1993) discusses the differences and potential issues involved in whether a therapist should meet the desires or needs of a patient. Mitchell (1995) further discusses the concept of desire in the context of Lacan's (1977, 1978) theory. These contributions will be used as a reference and a point of departure.

Needs:

As infants, we all have needs which can only be met with the help of the caregiving other. Often referred to as basic needs, they range from nursing and eating to being changed, kept clean, and comforted. As a very young infant, Mother (defined here as the primary caregiver) may never be too far away and the satiation of needs seems instantaneous. This immediacy contributes to the infant's feeling of omnipotence. Without intention and as time goes on, there will certainly be times when Mother is not as readily available. The baby's needs, therefore, feel frustrated. According to Kohut (1977), this frustration is necessary and growth-promoting. The child's sense of omnipotence wanes and this marks the beginning of a distinction between self and other. Eventually, this leads to loving Mother as a separate human being rather than purely as a need-gratifying object. Hence, the baby is on the path toward healthy object relations. The other side of the coin, however, is not as promising. A baby who never experiences frustration will be less able to distinguish between self and other and more likely to develop some form of pathology.

On the other hand, there are babies whose needs may not be satisfactorily met. These may be the individuals who, later, seek psychotherapy to heal the narcissistic injuries. Indeed, part of a therapist's job is to help patients heal past wounds. In other words, where a child was not provided with a sufficient mirroring object, this psychological gap could be filled therapeutically. Through the transference, the therapist takes on the characteristics of the patient's mothering object.

Desire:

To contrast need with desire, Lacan's (1977, 1978) concept of desire will be helpful. For Lacan, desire represents a focal point in his psychoanalytic work. Throughout his writing, Lacan argues that one's desire is the desire of the Other. Moreover, one's desire is to become that

which the other desires. To further clarify, Lacan defines desire as the point at which demand separates from need. Through language acquisition, infantile needs evolve into demands. Desire -- the wish to become the other's desire -- originates somewhere in between. The way in which desire exceeds the basic needs is easily recognized. Thus, Lacan's description of desire renders it both insatiable and impossible to attain according to Mitchell's (1995) interpretation. This can be a valuable way to conceptualize the notion of desire in a therapeutic setting as well.

As with the caregiving object of infancy, the therapist will also unintentionally frustrate the patient's needs. In fact, Mitchell (1993) suggests that this frustration provides the impetus for necessary and growth-promoting change. Yet, as stated earlier, gratifying the needs of a patient is acceptable. That it cannot, and should not, always occur is an important distinction; such frustration serves as a similar tool to the patient as it did for the infant who was learning to differentiate between self and other. The patient will use these frustrations to recognize the therapist's human fallibility which serves to dissolve the idealization of the therapist and, thus, make the therapist more human.

There is support for Mitchell's view of the therapeutic role of frustration. Gutheil and Gabbard (1993) distinguish between a patient's "libidinal demands" and his/her "growth needs". These concepts are easily compared to the needs versus desires framework and can be understood in the following way: the gratification of libidinal demands necessarily causes boundary violations whereas the exact opposite occurs with growth needs. Therapeutic change is prevented if these needs are not gratified to some degree. Thus, according to the proposed model, granting libidinal demands or desires would constitute a violation whereas granting growth needs would not.

In these terms, the potential damage the patient may experience through the gratification of desires is clear. For example, there is the danger of promoting omnipotence, idealization of the relationship, and unrealistic expectations.

Looking at this approach with an example may be helpful here. Recall the scenario of Heyward's (1993) case in which her therapist would not consider a post-treatment friendship. In her book, Heyward presents a compelling case for her own belief that her therapist would and should become her friend. The therapist, as described by Heyward, behaved in a manner which indicated a mutually engaging and satisfying relationship. Having been in other therapeutic relationships which allowed for post-termination friendship, Heyward was, therefore, inclined to believe that such a possibility existed.

The ethical dilemma most salient in this particular story is not whether the therapist should or should not have granted Heyward's wish to develop a post-treatment friendship. Many patients will see their therapist as a friend due to the unique and powerful alliance that is created and shared. Heyward requested consultations with other therapists when her therapist angrily (according to Heyward) resisted the idea of a friendship. According to Heyward's account, the reader is left feeling as though the therapist did want a friendship, but was torn about the boundary issue within herself. This is precisely at the heart of the dilemma. In this case, however, the therapist refused a consultation and therapy was terminated with the instruction that Heyward never contact her again. Obviously, only one side of this case is available for discussion and the reader is reminded that it's purpose is purely illustrative.

Not knowing all the relevant facts in the case, it would be impossible to determine whether Heyward's wish for friendship stems from need or desire. Let us assume that it was rooted in desire and, therefore, unacceptable to gratify. Based on this approach, one could then

conclude that the therapist made a sound decision. However, the fact that the therapist would not seek consultation with Heyward and would not allow further contact is another issue. Again, a lack of information makes this questioning difficult at best, but it seems that Heyward may have needed a different, more empathic type of closure and that particular refusal left Heyward feeling violated. Making one decision may pose new questions altogether and each must be considered by weighing the potential harm to the patient. One ethical and appropriate decision does not necessarily conclude the dilemma completely. By not taking her sound judgment to the next level, Heyward's therapist left her patient feeling that a boundary violation had occurred -- a condition the therapist attempted to avoid.

To further illustrate the model, another example may be valuable. Consider the use of non-erotic touch in the following scenario:

Scenario 1) A patient is sobbing uncontrollably.

Scenario 2) Prior to leaving for the day, a patient requests a hug.

In the second scenario, the fact that the patient possesses the ego strength and skill to make the request suggests that it is related to a desire. In fact, Mintz (1969) makes such a distinction between patients who can verbally request physical contact versus those who cannot. Those who can are assumed to be capable of making the same request in a non-symbolic relationship as well. Recall Mitchell's (1993) discussion which describes the primary needs of an infant. Clearly, Scenario 1 more closely resembles these type of needs. Indeed, this is consistent with Mintz who argues that touch is acceptable as symbolic mothering, as well as with O'Hearne (1972). In addition, even Epstein (1994), who favors more strict boundaries, calls on therapists to act as their patient's ego boundary which is another primary need.

There are other ways in which this alternative framework may be useful in making ethical decisions. Its very nature allows other questions to be considered which are not necessarily primary in other models. For example, issues of the patient's age, gender, and culture or ethnic background would all be a piece of the question of needs and desires. Obviously, a child or adolescent patient will have very different needs than an adult. Similarly, if one holds the belief that women and men have different emotional needs, that belief would be a crucial component of the decision-making process in this type of model. Likewise, some cultures have different concerns and needs around issues of touch or emotional interactions. It is possible that this type of framework can capture the nuances of these various issues in ways that other models cannot.

In order to utilize a theoretical approach to the decision-making process such as the one proposed here, the need for intense clinical training should be clear. Though this model may not prove valuable for addressing every type of dilemma, anything that can contribute a new way of addressing an old problem should be worth consideration.

Conclusion:

Although the Code of Conduct prohibits and prescribes certain behavior and is ambiguous about others, it does not propose a decision-making model. The various positions with respect to loose and strict boundary construction demonstrate the ambiguity which exists among professionals in the field. However, this examination of the subject has uncovered a few certainties: the need for increased education and awareness for therapists, therapists in training, and the patient population is an absolute necessity. In addition, the amount of subjectivity is reflective of the nature of such ethical dilemmas inasmuch as there may never be absolute right or wrong solutions. Therefore, understanding several opposing viewpoints and sets of guidelines can only serve to strengthen one's awareness of a difficult and complex subject matter.

While this new theoretical approach does not eliminate the problem of subjectivity, nor does it make the decision a clear-cut one, it does frame the question in a different way. If one accepts the validity of the need versus desire framework, it is clear that considering the potential harm to the patient is inherently the first and foremost consideration. This shift in thinking allows the focus of our questions to remain on the patient's needs. Furthermore, this model can easily address many different types of boundary questions. Although a therapist's decision will never be infallible, the raising of boundary issues in and of itself can provide critical therapeutic material. It is hoped that this model will be useful in considering all types of boundary dilemmas.

References

Epstein, R. & Simon, R. (1990). The exploitation index: An early warning indicator of boundary violations in psychotherapy. Bulletin of the Menninger Clinic, 54, 450-465.

Epstein, R. (1994). Keeping boundaries. Washington, D.C.: American Psychiatric Press, Inc.

Gerson, B. (1996). The therapist as a person. London: The Analytic Press.

Greenspan, M. (1986). Should therapists be personal? Self-disclosure and therapeutic distance in feminist therapy. Women and Therapy: A Feminist Quarterly, 5, 5-17.

Gutheil, T. & Gabbard, G. (1991). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. American Journal of Psychiatry, 150(2), 188-196.

Haas, L., & Malouf, J. (1995). Keeping up the good work. Sarasota, FL: Professional Resource Press.

Heyward, C. (1993). When boundaries betray us. New York: HarperCollins Publishers.

Holub, E., & Lee, S. (1990). Therapists' use of nonerotic physical contact: Ethical concerns. Professional Psychology: Research and Practice, 21, 115-117.

Kertay, L. & Reviere, S. (1993). The use of touch in psychotherapy: Theoretical and ethical considerations. Psychotherapy: Theory/Research/Practice/Training, 30, 32-40.

Kohut, H. (1977). The restoration of the self. New York: International Universities Press.

Lacan, J. (1977). Écrits: A selection (Alan Sheridan, Trans.). New York: Norton.

Lacan, J. (1978). The four fundamental concepts of psychoanalysis (Jacques-Alain Miller, Ed., Alan Sheridan, Trans.). New York: Norton.

Lerman, H. & Porter, N. (Eds.) (1990). Feminist ethics in psychotherapy. New York: Springer Publishing Company.

Miller, W., & Lee, S. (1990). Ethical considerations of establishing post treatment friendships between therapists and former clients. Psychotherapy in Private Practice, 7, 75-81.

Mintz, E.E. (1969). On the rationale of touch in psychotherapy. Psychotherapy: Theory, Research, and Practice, 6(4), 232-234.

Mitchell, S. (1993). Hope and dread in psychoanalysis. New York: Basic Books.

Mitchell, S. (1995). Freud and beyond. New York: Basic Books.

O'Hearne, J.J. (1972). How can we reach patients most effectively? International Journal of Group Psychotherapy, 22, 446-454.

Phillips, C., & Lee, S. (1986). The psychologist as a friend: The ethics of the psychologist in nonprofessional relationships. Professional Psychology: Research and Practice, 17, 293-294.

Pope, K., Sonne, J., & Holroyd, J. (1994). Sexual feelings in psychotherapy. Washington, D.C.: APA.

Simon, R. (1992). Treatment boundary violations: Clinical, ethical, and legal considerations. Bulletin of the American Academy of Psychiatry and Law, 20(3), 269-288.

Smith, D. & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. Professional Psychology: Research and Practice, 26(5), 499-506.

Sonne, J.L. (1994). Multiple relationships: Does the new ethics code answer the right questions? Professional Psychology: Research and Practice, 25(4), 336-343.

Wooley, S. (1994). The female therapist as outlaw. In P. Fallon, M. Katzman, & S. Wooley (Eds.), Feminist perspectives on eating disorders (pp. 318-338). New York: The Guilford Press.

BEST COPY AVAILABLE